WATER AND POWER EMPLOYEES' RETIREMENT PLAN
ROOM 357 - 111 NORTH HOPE STREET
BOX 51111 - LOS ANGELES, CA 90051

DOCTOR'S CERTIFICATE

_____
Medical Record No.

_____
Employee's Name (last, first and middle initial) Employee's Number

This form is to verify disability. It is not a medical insurance form.

Instructions to attending physician: Please complete this form to prevent delays in the receipt of disability benefits by your patient.

Diagnosis (with degree of severity): _____

_____

_____

_____

If trauma, give cause: _____

_____

What limitation justifies the absence from work?: _____

_____

Work related: _____ YES _____ NO If pregnancy, date of confinement: _____

Date of first treatment for this disability: _____

Date of most recent treatment: _____

Hospitalization required: _____ YES _____ NO _____ Admit Date _____ Discharge Date

Date and nature of surgery: _____

Hospital name and address: _____

_____

Employee is able to return to work: _____
Month Day Year

I CERTIFY THAT THE ABOVE STATEMENTS, IN MY OPINION, DESCRIBE THE PATIENT'S CONDITION.

_____ _____ _____ _____
Date Specialty Degree Doctor's name (please print)

( ) _____ _____
A/C Telephone number Address (street, city, state, zip code)

Orig.: Disability Office
Copy: DWP Medical Office
Copy: Attending Physician

_____
Doctor's Signature

FORM RP 027

THIS REPORT WILL BE REVIEWED BY A PHYSICIAN